Department of Workforce Development
Worker's Compensation Division
201 E. Washington Ave., Rm. C100
P.O. Box 7901
Madison, WI 53707-7901
Imaging Server Fax: (608) 260-2503
Telephone: (608) 266-1340
Fax: (608) 267-0394
http://www.dwd.state.wi.us/wc/
e-mail: DWDDWC@dwd.state.wi.us

SOCIAL SECURITY INFORMATION REQUEST

The provision of your social security number is mandatory under Wisconsin Statutes and will be used to identify the claimant. Failure to provide it may result in penalties or delayed payment of benefits.

Personal information you provide may be used for secondary purposes [(Privacy Law, s. 15.04(1)(m)].

See Reverse Side for Instructions

1. WC Claim Number	2. Employee Name
3. Social Security Number	4. Employee Mailing Address (number, street, city, state, zip code)
5. Injury Date	

Social Security Release Authority - To be completed by employee

I authorize the Social Security Administration to release the information requested below to:

6. Insurance Company Representative or Self-Insured Employer Name	7. Mailing Address (number, street, city, state, zip code)

I understand that the information requested is for computing the amount of worker's compensation payments for which I would be entitled. The information below is not to be disclosed to others or to be used for other purposes without my additional consent.

This authorization shall remain in effect for one year from the date below or until revoked by me in writing if earlier.

8. Signature (do not print)	9. Date Signed	10. Social Security Number (only if different from above)

Office Use Only

Social Security Disability Benefit Information

11. Status of Disability Claim

☐ Approved ☐ Denied ☐ Pending ☐ No Claim Filed

12. 80% of Monthly Average Current Earnings (ACE) $_____

13. Disability MBA for W/E at Initial Entitlement $_____

14. Month and Year of Entitlement _____

15. Month and Year of Last Disability Check if Terminated _____

16. SSA Representative Signature	17. Date Signed	18. Telephone Number	19. Office Location

SSA INSTRUCTIONS

Insurance Company or Self Insured Employer

1. Enter WC claim number
2. Enter employee's name
3. Enter employee's social security number
4. Enter employee's address
5. Enter injury date
6. Enter your name
7. Enter your mailing address

- Send this form to the employee

Employee

8. Provide your signature, do not print
9. Enter date of your signature
10. Enter your social security number only if it is different from the number in "3."

- Important Notice: Return this form to the address in "7." within 30 days. If you do not sign this form, your insurance carrier or employer can reduce your benefits by 75%. When you sign, any benefits that were withheld will be paid to you.

Insurance Company or Self Insured Employer

- Once you receive this form from the employee, send the signed form to the SSA district office that handles this employee.

Social Security Administration

- See TN 11 2-83 D100203.050
  If any of the information below is not available, forward this form to Baltimore. The insurance carrier needs all this information, except Line 15, to compute a reverse offset.

  If the claim is currently being reviewed but payments were made in the past, please follow the instructions for 11 through 18:

11. Enter status of the disability claim
12. Enter 80% of ACE
13. Enter MBA
14. Enter month and year of entitlement
15. Enter month and year of last disability check (only if benefits are ending)
16. Have Social Security Administration representative's signature
17. Enter date of Social Security Administration representative's signature
18. Enter telephone number of Social Security Administration representative for possible questions from insurance carrier
19. Enter city

- Send this completed form to the address in "7."

Insurance Company or Self Insured Employer

- Fill out a *Social Security Reverse Offset Worksheet*. If you find that you can take an offset, send copies of this form and the Worksheet to:

  Worker's Compensation Division
  P.O. Box 7901
  Madison, WI 53707

- The employee and Social Security Administration representative must sign this form or Reverse Offset will not be computed. Computerized forms from the Social Security Administration will not be accepted.